DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
Olympia, Washington

To: Dental Providers
Managed Care Plans

Memorandum No: 04-91 MAA
Issued: December 17, 2004

From: Douglas Porter, Assistant Secretary
Medical Assistance Administration (MAA)

For Information Call:
1-800-562-6188

Subject: Dental Program (Adults/Children): Fee Schedule Changes

Effective for dates of service on and after January 1, 2005, the Medical Assistance Administration (MAA) is implementing the Current Dental Terminology (CDT) procedure code additions as discussed in this memorandum. Maximum allowable fees for the Year 2005 additions are also included.

New Code for Children's Dental Services

Effective for dates of service on and after January 1, 2005, MAA is adding the following new dental procedure code for **Children's Dental Services only:**

CDT Procedure Code	Brief Description	1/1/05 Maximum Allowable Fee
D7111	Coronal remnants deciduous t	$29.00

New Code for Adult Dental Services

Effective for dates of service on and after January 1, 2005, MAA is adding the following new dental procedure code for **Adult Dental Services only:**

CDT Procedure Code	Brief Description	1/1/05 Maximum Allowable Fee
D7111	Coronal remnants deciduous t	$33.14

Note: MAA is adding procedure code D7111 to the GA-U listing of allowable codes for both the Children and Adult Dental Programs. MAA is also fixing replacement page D.9 to reflect the correct covered GA-U procedure codes.

Upcoming changes to the Dental Program

MAA is working on updating the Washington Administrative Code for the Orthodontics for Children, the Children's Dental program. Please visit the new MAA Dental web site: http://fortress.wa.gov/dshs/maa/ProvRel/Dental/Dental.html to find the latest information and to contact MAA with questions and suggestions.

Billing Instructions Replacement Pages

Attached are replacement pages D.9/D.10, D.41/42, E.9/E.10, E.35/36 for MAA's current ***Dental Program (Adults/Children) Billing Instructions***. **Note: Pages D.10, D.41, E.10, and E. 36 have no added or deleted codes; MAA is including them because they are attached to the back or front of a changed page.**

How can I obtain MAA's Provider Issuances?

To obtain MAA's numbered memoranda and billing instructions, visit MAA's website at http://maa.dshs.wa.gov (select the *Billing Instructions/Numbered Memoranda* link).

To request a free hard copy from the Department of Printing:

- **Go to:** http://www.prt.wa.gov/ (Orders filled daily)
  Click on General Store. Follow prompts to Store Lobby → Search by Agency → Department of Social and Health Services → Medical Assistance Administration → desired issuance; **or**

- **Fax/Call:** Dept. of Printing/Attn: Fulfillment at FAX (360) 586-8831/ telephone (360) 586-6360. (Orders may take up to 2 weeks to fill.)

GA-U/GA Covered Procedure Codes:

ADA	11646	21044	40806
D0140	12001	21045	40808
D0220	12002	21076	40816
D0230	12004	21077	40819
D0330	12005	21141	40831
D3310	12011	21142	41000
~~D3320~~	12013	21143	41005
~~D3330~~	12015	21336	41006
D7111	12016	21337	41007
D7140	12031	21344	41008
D7210	12032	21346	41009
D7220	12034	21347	41010
D7230	12035	21348	41015
D7240	12051	21355	41016
D7241	12052	21356	41017
D7250	12053	21360	41018
D9110	12054	21365	41108
D9220	12055	21366	41825
D9420	13131	21385	41827
D9630	13132	21406	41830
	13133	21407	41874
	13150	21408	42106
CPT	13151	21421	42180
11044	13152	21422	42182
11100	13153	21423	42200
11101	13160	21436	42205
11440	14040	21445	42210
11441	20220	21453	42220
11442	20520	21462	42225
11443	20670	21465	42227
11444	21025	21470	42235
11446	21030	21480	42280
11640	21031	21550	42281
11641	21032	30580	
11642	21034	30600	
11643	21040	40800	
11644	21041	40801	

Billing Procedures

1. The major procedure and all ancillary services must be billed as one treatment plan. Ancillary services will not be considered separately.

2. MAA may require reports and/or radiographs to make an authorization determination. In your request for prior authorization, be sure to include a written justification in *field 35* of the ADA claim form. Remember to mark any radiographs you send with your name and provider number.

   For detailed instructions on how to complete an **ADA claim form**, refer to Section H.

3. Submit the original claim *(make sure the client's PIC is on the claim)*, and any necessary authorization documentation. When MAA returns the original to you, look at the Dental Consultant section for the authorization number and any pertinent comments by the Dental Consultant.

What dental-related services are not covered for children?

[Refer to WAC 388-535-1100(1)(2)]

MAA does not cover the following dental-related services unless the services are:

a) Required by a physician as a result of an EPSDT screen as provided under chapter 388-534 WAC; or
b) Included in an MAA-waivered program

MAA does **not cover** the following services for children:

a) Any services specifically excluded by statute.

b) **More costly services** when less costly, equally effective services as determined by the department are available;

c) Services, procedures, treatments, devices, drugs, or application of associated services that the department or the Centers for Medicare and Medicaid Services (CMS) consider investigative or experimental on the date the services were provided.

d) **Routine fluoride treatments** (gel or varnish) for clients age 19 through 20 unless the clients are:

   i. Clients of the Division of Developmental Disabilities (see page D.10);
   ii. Diagnosed with xerostomia, in which case the provider must request prior authorization.

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable 0-18 yrs	Maximum Allowable 19 –20 yrs

Prosthodontics, Fixed Repairs

D6930	**Recement fixed partial denture (bridge)**	No	$34.00	$32.58

Management of Temporomandibular Joint Dysfunction

D7880	**Occlusal orthotic device** **[Allowed for TMJ/TMD or bruxism only.]** Laboratory-processed only. Requires prior authorization. Justification must include diagnosis. Laboratory invoice must be kept in the client's file. The maximum allowance includes all professional fees, lab costs, and all required follow-ups. One appliance allowed in a two-year period. **Use the seat date to bill for occlusal orthotic device.**	**Yes**	**By Report**	**By Report**

Procedure Code	Description/Limitations	Prior Auth?	01/01/05 Maximum Allowable 0-18 yrs	19 –20 yrs

Oral Surgery – Dentists

MAA covers dental services that are medically necessary and provided in a non-office setting under the direction of a physician or dentist for:

a) The care or treatment of teeth, jaws, or structures directly supporting the teeth, if the procedure requires hospitalization;
b) Short stays or ambulatory surgery centers when the procedure cannot be done in an office setting (See "What dental-related services are not covered," page D.10; and
c) A hospital call, including emergency care, allowed one per day, per client, per provider.

Simple Extraction

(includes local anesthesia, suturing, if needed, and routine postoperative care)

D7111	**Coronal remnants deciduous t**	No	$29.00	$33.14
D7140	**Extraction, erupted tooth or exposed root (elevation and/or forceps removal)**	No	$58.26	$33.14

Surgical Extractions

(includes local anesthesia, suturing, if needed, and routine postoperative care)

D7210	**Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth** Surgical removal of anterior teeth (7-10 and 23-26) require prior authorization and must be justified with radiographs. Tooth designation required.	**See Desc.**	$90.00	$65.00
D7220	**Removal of impacted tooth – soft tissue** Tooth designation required.	No	$90.90	$76.71
D7230	**Removal of impacted tooth – partially bony** Tooth designation required.	No	$130.00	$120.00
D7240	**Removal of impacted tooth – completely bony** Allowed only when pathology is present. Tooth designation required.	No	$150.00	$140.00
D7241	**Removal of impacted tooth - completely bony, with unusual surgical complications** Allowed only when pathology is present. Tooth designation required.	No	$200.00	$180.00
D7250	**Surgical removal of residual tooth roots (cutting procedure)** Extraction must be performed by a different provider. Tooth designation required.	No	$80.80	$48.34
MAA does not cover extraction of asymptomatic teeth. [WAC 388-535-1100(2)]				

GA-U/GA Covered Procedure Codes:

CDT	11640	13152	21385	41007
D0140	11641	13153	21406	41008
D0220	11642	13160	21421	41009
D0230	11643	14040	21422	41010
D0330	11644	20220	21423	41015
D3310	11646	20520	21431	41016
D7111	12001	21030	21432	41017
D7140	12002	21034	21433	41018
D7210	12004	21040	21435	41100
D7220	12005	21041	21436	41105
D7230	12011	21044	21445	41108
D7240	12013	21045	21452	41110
D7241	12014	21046	21453	41112
D7250	12015	21047	21454	41113
D9110	12016	21141	21461	41114
D9220	12031	21142	21462	41825
D9420	12032	21143	21470	41826
D9630	12034	21336	30580	41827
	12035	21337	40800	42100
	12051	21344	40801	42104
CPT	12052	21345	40804	42106
11100	12053	21346	40805	42180
11101	12054	21347	40808	42182
11440	12055	21348	40810	42235
11441	13131	21355	40812	
11442	13132	21356	40814	
11443	13133	21360	41000	
11444	13150	21365	41005	
11446	13151	21366	41006	

See page E.17 – Dental Fee Schedule for Maximum Allowable Fees, Limitations, and Additional Required Documentation

What dental services are not covered for adults?

[Refer to WAC 388-535-1265(1) and (2)]

MAA does not cover the following dental services unless the services are:

- Included in a MAA-waivered program; or
- Part of one of the Medicare programs for Qualified Medicare Beneficiaries (QMB), except for QMB-only, which is not covered.

MAA does **not cover** the following dental-related services for adults:

a) **Any services specifically excluded by statute**.

b) **More costly services** when less costly, equally effective services as determined by the department are available;

c) Services, procedures, treatments, devices, drugs, or application of associated services which the department of the Centers for Medicare and Medicaid Services (CMS) consider **investigative or experimental** on the date the services were provided;

d) Coronal polishing;

e) **Fluoride treatments (gel or varnish) for adults**, unless the clients are:

i. Clients of the Division of Developmental Disabilities;
ii. Diagnosed with xerostomia, age 19-64, in which case the provider must request **prior authorization**; or
iii. High-risk adults, 65 years of age and older. High-risk means the client has at least one of the following:

A. Rampant root surface decay; or
B. Xerostomia.

f) **Restorations** for wear on any surface of any tooth without evidence of decay through the enamel or on the root surface**.**

g) Flowable composites for interproximal or incisal restorations;

h) Nitrous oxide, except as provided for clients of the Division of Developmental Disabilities (see page E.6);

i) Behavior management, except as provided for clients of the Division of Developmental Disabilities (see page E.6);

j) Occlusal adjustments

Procedure Code	Description/Limitations	Prior Auth?	01/01/05 Maximum Allowable 21 yrs & up

Oral Surgery – Dentists

MAA covers dental services that are medically necessary and provided in a non-office setting under the direction of a physician or dentist for:

a) The care or treatment of teeth, jaws, or structures directly supporting the teeth, if the procedure requires hospitalization;
b) Short hospital stays or ambulatory surgery centers when the procedure cannot be done in an office setting (See "What dental-related services are not covered," page E.10); and
c) A hospital call, including emergency care, allowed once per day, per client, per provider.

Simple Extraction

(includes local anesthesia, suturing, if needed, and routine postoperative care)

D7111	**Coronal remnants deciduous t**	No	$33.14
D7140	**Extraction, erupted tooth or exposed root (elevation and/or forceps removal)**	No	$33.14

Surgical Extractions

(includes local anesthesia, suturing, if needed, and routine postoperative care)

D7210	**Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth** Anterior teeth (7-10 and 23-26) require prior authorization and must be justified with radiographs. Tooth designation is required.	See desc	$65.00
D7220	**Removal of impacted tooth – soft tissue** Tooth designation is required.	No	$76.71
D7230	**Removal of impacted tooth – partially bony** Tooth designation is required.	No	$120.00
D7240	**Removal of impacted tooth – completely bony** Allowed only when pathology is present. Tooth designation is required.	No	$140.00
D7241	**Removal of impacted tooth - completely bony with unusual surgical complications** Allowed only when pathology is present. Tooth designation is required.	**Yes**	$180.00
D7250	**Surgical removal of residual tooth roots (cutting procedure)** Extraction must be performed by a different provider. Tooth designation is required.	No	$48.34

MAA does not cover extraction of asymptomatic teeth. [WAC 388-535-1100(2)]

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable 21 yrs & up

Adjunctive General Services

Unclassified Treatment

D9110	**Palliative (emergency) treatment of dental pain – minor procedure** • Emergency palliative treatment is: ✓ Covered only when no other definitive treatment is performed on the same day; and ✓ Covered once per client, per day. • A description of the treatment performed must be documented in the client's record. • Not allowed when performed on the same date as root canal therapy.	No	$45.00